F I S C A L I M P A C T R E P O R T

SPONSOR SJC **ORIGINAL DATE** 1/25/17 **LAST UPDATED** 3/16/17 **HB**

SHORT TITLE Medical Marijuana Changes **SB** CS/CS/177/SPACS/SJCS/aSFl#1/aHJC

ANALYST Chenier

REVENUE (dollars in thousands)

Estimated Revenue				Recurring or Nonrecurring	Fund Affected
FY17	FY18	FY19	FY20		
		$1,500.0	$1,500.0	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total			$511.4	$511.4	Recurring	Medical Cannabis

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to Senate Bill 8

SOURCES OF INFORMATION
LFC Files

Responses Received From
Department of Health (DOH)
Veterans' Services Department (VSD)

SUMMARY

Synopsis of HJC Amendment

The House Judiciary Committee amendment to the Senate Judiciary Committee substitute for the Senate Public Affairs Committee substitute for Senate Bill 177 adds intractable nausea or vomiting to the list of debilitating medical conditions.

Synopsis of Senate Floor Amendment #1

Senate Floor amendment number 1 to the Senate Judiciary Committee substitute for the Senate

Public Affairs Committee substitute for Senate Bill 177 eliminates language allowing persons to obtain a medical cannabis identification card based solely on veteran status and eliminates the definition of chronic condition. The amendment also defines written attestation, eliminates Section 5, and replaces it with a provision allowing a qualified patient or caregiver to obtain a registry identification card upon submittal of the written attestation. The amendment also makes small technical changes.

Synopsis of SJC Substitute

Senate Bill 177 as substituted by the Senate Judiciary Committee and the Senate Public Affairs Committee adds 14 conditions to the definition of debilitating medical condition qualifying a person to obtain a medical cannabis registry identification card. Personal production license, registry identification card, tetrahydrocannabinol (THC), and substance use disorder are newly defined.

Further the bill would remove DOH's authority to determine by rule "adequate supply" of medical cannabis. Also, the bill would allow for interstate reciprocity not requiring out of state card holders to participate in New Mexico's registration card application and renewal process. If a patient is a veteran or if the patient's debilitating condition is considered chronic, then reapplication would be required no sooner than three years from the date of issuance. However, if the condition is not chronic, reapplication would be no sooner than three years but the patient would be required to submit a statement from a practitioner annually. The bill would not allow the department to limit the amount of THC concentration in a cannabis derived product.

The bill sets licensure fees of $30 thousand for the first 150 plants, $10 thousand for each additional 50 plants, and a licensure fee limit of $90 thousand. Additionally, the bill sets statutory limits on the possession of medical cannabis as listed in the table below but would not allow the department to reduce plant counts if the patient census decreases.

Patient, Personal Production, and Licensed Producer Medical Cannabis Possession Limits		
Type	**Patient Census**	**Number of Plants**
Qualified Patient	N/A	5 ounces
Qualified Patient with Personal Production License	N/A	18
Licensed Producer	35,000	500
Licensed Producer	40,000	600
Licensed Producer	45,000	700
Licensed Producer	50,000	800
Licensed Producer	55,000	900
Licensed Producer	60,000	1,000
Licensed Producer	65,000	1,100
Licensed Producer	Each additional 5,000 increase	"+100"

Also, the bill would not allow children to be removed and placed into state custody based solely on an individual's participation in the medical cannabis program. Lastly, the bill would not allow someone to be precluded from receiving an anatomical gift due to their participation in the program.

FISCAL IMPLICATIONS

Currently, Section 26-2B-1 NMSA 1978 provides the Department of Health with administrative flexibility to limit the number of licensed nonprofit producers (currently set at 35) and limit the number of cannabis plants a producer is allowed to possess (currently set at 450). Licensed producers are charged a fee of $200 per plant and at any given time as many as 15,750 plants are allowed to be in production. In FY18 licensed producers are expected to pay fees on about 13,800 plants amounting to $2.76 million. The sole source of revenue for the Medical Cannabis Program is licensing and fees.

Assuming the total statewide licensed producer plant count in FY18 will be 13,800 the program would be expected to generate $2.76 million, likely covering operating costs.

(13,800 plants ÷ 50) x $10,000 plant fee = $2.76 million

In subsequent years, assuming patient census grew to 45,000 and assuming licensed producers reached 87 percent of allowable capacity, as is expected to happen, an additional 7,500 plants would enter production. Given these assumptions it is likely the bill in FY19 would generate an additional $1.5 million.
(7,500 additional plants ÷ 50) x $10,000 plant fee = $1.5 million

Unexpended revenue to the program reverts to the general fund and assumptions about plant production and patient demand are guesses and actual production may vary greatly.

DOH stated that the Medical Cannabis Program would need to hire new staff in the licensing and compliance division and new staff for the patient services division. Projected annual costs include: inspectors plus benefits (4 FTE costing $272 thousand); information and records clerks (3 FTE costing $127.4 thousand); additional office space costing $60 thousand; and two vehicles costing $52 thousand for a total annual cost of $511.4 thousand.

Dependent on the patient census, it is likely that many of these costs would not be realized until several years after enactment and would likely be covered by production fees.

SIGNIFICANT ISSUES

Some states have restrictions on the number of plants producers are allowed to have and other states such as Nevada and Arizona have none. California and Washington limit the square footage of plant production facilities and other states such as Delaware, Maine, and New Hampshire limit plant counts based on patient need.

DOH provided the following:

> With the addition of subsection K, the floor amendment identifies written attestation as being a written statement from a qualified patient that states that the qualified patient has been diagnosed by a practitioner as having a debilitating medical condition, the qualified patient continues to receive care from a practitioner for the debilitating condition, states benefits outweigh the risk, and provides the name and address of the medical practitioner. This subsection seems to indicate that this would be the only item needed for recertification.

Many of the applicants in the Medical Cannabis Program have stated to program staff that they do not receive ongoing care and, in fact, rely on medical cannabis as their primary treatment. There is some evidence that cannabis can be a cause of cyclical vomiting for longtime users, a cause of psychosis for others, and cannabis masking symptoms from other conditions that can be treated if properly and timely diagnosed. From a harm reduction perspective, documentation from a provider that the applicants are in fact getting some medical evaluation to mitigate for adverse effects or development of new diagnosis would be appropriate. While the attestation allows for the Medical Cannabis Program staff to confirm ongoing treatment is occurring, the Department does not have the staff capacity to confirm ongoing care for each applicant.

It is unclear what effect presumptive eligibility would have on DOH's processing of applications. However, it can be anticipated that DOH could be required to issue an enrollment card, even though it was awaiting further information from a certifying practitioner for verification purposes. If DOH later discovered that it needed to rescind the issuance of an enrollment card due to the information provided being false, it would need to provide the opportunity for an evidentiary hearing to the affected applicant.

The supply limit proposed by the bill does not distinguish between dried usable cannabis material and cannabis-derived products. Cannabis derived products (CDPs) include concentrates, edible products, salves, etc. As noted, 7.34.3.9 NMAC utilizes a "unit" based system, in which one gram of dried usable cannabis or 200 milligrams of THC in a cannabis derived product, constitute a unit. THC is the primary psychoactive ingredient in cannabis. The THC-based equivalency was adopted to avoid creating an arbitrary possession limit for CDPs. As SB8 is written, the possession limit would be based solely on weight, and as such, there would be no distinction made between dried material containing 18 percent THC and a concentrate containing 70 percent THC.

The bill would modify this standard, increasing the quantity that a qualified patient may possess to five ounces at any given time, or, if the qualified patient holds a personal production license, would permit the patient to possess however much cannabis the patient is able to grow by harvesting plants. Both standards would constitute significant increases to the quantity of cannabis that patients and primary caregivers may possess. Under the bill, the quantity of cannabis a patient could legally possess would result in New Mexico having the fifth highest possession limit of all State programs.

The bill defines a "chronic" condition to mean "a condition that, in the opinion of a patient's practitioner, lasts or is expected to last three months or longer." By this definition, essentially every current qualifying condition would be deemed chronic. This would mean, that virtually every patient in the program would submit a medical certification once every three years.

The bill would require the program to issue enrollment cards within 24 hours of receipt of a complete application. This may not be a realistic goal with the current staffing and the number of applications received daily. While the processing of applications is the primary function of the Patient Services portion of MCP, the reality is there are many other responsibilities placed on the program related to the day-to-day operations.

> One of the recent developments in the cannabis industry is the increased production, distribution, and usage of concentrated THC products that contain substantially more THC than ordinary dried cannabis material. These products are commonly produced via complex extraction methods that utilize compressed gas. Utilizing these methods, it is possible to create extremely high concentrations of THC, which may be consumed by vaporizing the product, and by other means of ingestion. The consumption of these cannabis concentrates has not been widely studied, and there is no established medical standard for appropriate dosages of such products.

OAG in response to Senate Bill 8 stated that by providing a statutory presumption to an applicant's eligibility for a registry identification card in accordance with the Act, it could limit the Department from denying the application on other grounds, such as the Department's own analysis as to whether or not a physician's written certification of a patient's diagnosis of having a debilitating medical condition and the physician's opinion of the potential health benefits of medical cannabis satisfies the Department's own review. However, the language of SB8 still provides that the application must be completed in accordance with "department rules."

TECHNICAL ISSUES

DOH was concerned that the floor amendment states that a qualified patient must be a resident of New Mexico. However, page 14 line 21 through page 15 line 5, of outlines requirements to allow for those enrolled in other state programs to be allowed to purchase product through the New Mexico program. By accepting out of State cards, the program would be negating the Qualified Patient definition as these participants would not be state residents

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